The Role of Social Support in the Aftermath of Sexual Assault: A Review

An Honors Thesis (HONR 499)

By

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Abstract

The role of social support in overcoming trauma has been well supported by the literature. Sexual assault is one of the most prevalent precursors to post-traumatic stress disorder in the United States, especially among women. The following review examines the role of informal social support, both positive and negative, in the development of PTSD and in post-assault recovery. While negative social reactions following a sexual assault disclosure is a significant predictive factor in the development of PTSD, positive social support can provide a buffering effect and promote faster recovery. The effects of social support are mediated by the survivor's perception of the support received.

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Process Analysis Statement

At the beginning of this process, I knew I wanted to examine social support and sexual assault. My original plan was to perform a meta-analysis on the available data and analyze the results from a statistical point of view. I quickly realized the available literature was not extensive enough to support a valid analytical review.

With that in mind, I changed course to an extended literature review, with the intent to expand on previous reviews and update with the latest studies on social support. I began thinking I would focus primarily on positive informal social support and its effects on post-assault recovery. As I began to collect data and sort through the available studies, I found a significant amount of research on negative social responses: invalidations, acceptance of rape myths, victim blaming, and disbelief. The more I looked, the more strong correlations I found between poor post-assault adjustment and negative responses. I decided to expand my review to include negative social support and its detrimental effects, instead of just positive social support.

As I continued my research, I began to find contradictory data—some studies found that social support contributed strongly to survivor recovery, while some found that the effect was almost negligible. While it would have been tempting to simply ignore contradictory studies, I knew I had to dig deeper. I found that the main source of the conflicting information seemed to be that researchers were using different definitions of social support, and measuring it in different ways. This made it very difficult to compare data.

I did, however, find a very important implication as I was trying to sort everything out: the actual reception of social support seemed to be much less important than the perception of the survivor. In other words, survivors perceiving themselves to have adequate social support had a much larger positive effect than how many supportive behaviors they were actually

receiving. This opened up a whole new line of inquiry, and I began to focus my paper on the perception of support, rather than just the behaviors of social support. This added a depth and nuance to my thesis, and has inspired many ideas for future research. I am now planning to continue researching along these lines, with the end goal of creating a more accurate way of measuring social support for future researchers to use.

The Role of Social Support in the Aftermath of Sexual Assault: A Review

Introduction

Sexual assault is a prevalent problem in the United States. According to the Department of Justice, sexual assault is defined as any sexual contact or behavior that occurs without the explicit consent of the recipient (Department of Justice, 2017). Statistics collected and analyzed by the Rape, Assault, and Incest National Network, or RAINN, indicate that approximately 300,000 victims were assaulted in 2014. This averages about to approximately one incident every 109 seconds. 90% of the total number of victims are female, and approximately 78% knew the perpetrator (Rape, Assault, and Incest National Network, 2016). According to the National Sexual Violence Resource Center, in the US, one in five women and one in seventy-one men will be raped at some point in their lives (2017).

Sexual assault is also common on college campuses. One study indicates that in a college with 10,000 female students, there may be more than 350 sexual assaults per year (Fisher, Cullen, & Turner, 2000). 11.2% of all students experience are raped or sexually assaulted (RAINN). Among undergraduate students, 28.5% are raped or sexually assaulted. 21% of all transgender, gender nonconforming, and genderqueer students are raped or sexually assaulted (Fisher et al., 2000.).

The Impact of Sexual Assault

The negative impact of sexual assault and harassment on an individual is often profound. Many survivors experience symptoms such as dissociation, sleep disturbance, increased risk of suicide attempts, and post-traumatic stress disorder or PTSD (Briere & Runtz, 1987), as well as anxiety and depression (Gidycz & Koss, 1991). These symptoms are especially common for women. A study by Tolin and Foa indicated that while men are more likely to experience a

potentially traumatizing event, such as witnessing violence, women are more likely to actually develop PTSD (2006). One explanation for this gender difference is that men are more likely to serve in the military, which explains the higher exposure to traumatic events (Tolin & Foa, 2006). As sexual assault can affect as many as 25% of women (Koss, 1993), the idea that women may be more susceptible to developing PTSD is a concerning one.

Experiencing trauma, such as sexual assault, is not the only predictor of PTSD development, or other symptoms such as depression and suicidality. Moderating factors for the severity of symptoms are attack severity, individual demographics, and post-assault response (Ullman & Filipas, 2001). Post-assault response, in this context, refers to the reactions that survivors receive when disclosing a sexual assault. The following review examines the role and impact of post-assault response, with special focus on informal social support.

Social Support

The role of positive social support after a traumatic experience has been well established by multiple researchers (Lepore, 2001, Wilson & Scarpa, 2013, Verhofstadt et al., 2007). A 1978 longitudinal study compared 92 adult survivors of rape, 19% of whom lacked access to friends and family who could meet psychosocial needs or emotional support (Burgess & Holstram). Within months, 45% of the group with social support had recovered (as measured with a subjective self-report on whether or not the rape was continuing to affect daily life and emotional state), while it took 4-6 years for 47% of the group without social support to recover. At termination of the study, 53% of the group without social support had not yet recovered, compared to only 20% of the group with social support (Burgess & Holstram, 1978). These findings suggest that the absence of social support is detrimental to post-assault recovery.

Approximately two-thirds of sexual assault survivors tell a second party about the assault

(Golding et al., 1989). For the purposes of the current review, second party responses have been categorized into two basic conceptualizations: positive informal social support (commonly referred to as social support in the literature) and negative social pressure. While there are many important professional services available to survivors, i.e., mental health counseling, legal advice, medical services, rape crisis centers, and victim advocacy, the impact of these will not be examined in detail in the following review. For further information about the utilization of professional services in post-assault recovery, see Golding and colleagues (1988).

Positive Informal Social Support. Social support can be loosely defined as a response that validates the experience and emotions of the survivor. This could include encouragement, empathic listening behaviors, and affirmation. Due to a lack of clear definitions, conclusive research on the effects of social support on survivors of sexual assault is difficult to find (Ullman, 1999). Some studies also expand the definition of social support to include financial, informational, or other tangible support (i.e., offering help with household chores, providing a referral to a doctor, or providing child care). One important distinction when looking at the literature is the difference between perceived support and received support.

Perceived support. In a 1992 study, Kanaisty and Norris differentiated between perceived support and received support. Researchers surveyed 807 households, 175 of which had been the victims of violent crime, 328 of which had experienced non-violent (property) crime, and 304 of which were non-victims. Participants completed a battery of surveys to measure the type of post-crime support they had received. Perceived social support refers to the individual's perception of support, i.e., how supported they feel. This variable was measured with a shortened version of the Interpersonal Support Evaluation List (ISEL; Cohen et al., 1985, as cited in Kanaisty & Norris, 1992). The ISEL consists of 18 questions measuring perceived appraisal

support (e.g, the availability of friends to provide guidance or comfort), perceived tangible support (e.g., the availability of friends to help with financial or physical needs), and perceived self-esteem support (e.g., the availability of friends to reassure self-worth). The ISEL focuses on whether or not the participant has confidence that his or her friends will provide help and support.

A second survey, the Inventory of Socially Supportive Behaviors (ISSB; Barrea, Sandler, & Ramsey, 1981, as cited in Kanaisty & Norris, 1992), was administered to measure received support. The ISSB asks participants to identify how frequently they have received support, either tangible (provision of material aid), informational (provision of guidance or advice), or emotional (expression of acceptance or concern). The key difference between the ISEL and the ISSB is that the ISEL measures the participant's perception of support, while the ISSB measures actual helping behaviors that the participant has received.

Participants who perceived support post-crime presented significantly fewer negative psychological symptoms, including depression and anxiety. Interestingly, received emotional support had no impact on the well-being of victims (Kanaisty & Norris, 1992). These data suggest that the individual's perception of support has a much greater impact than whether or not they are actually receiving tangible or emotional support.

These findings are supported by a 1991 study by Davis and Brickman. Researchers administered the Crime Impact Social Support Inventory (CISSI; Davis & Brickman, 1991) to a sample of 105 female survivors of sexual assault. The CISSI assesses supportive behaviors the participant has received from a significant other, such as expressed concern, physical affection, and helping with household chores. The CISSI also assesses unsupportive behaviors, such as victim blaming and emotional withdrawal. Analysis showed that supportive behaviors from a

significant other did not have a significant effect on survivor well-being. These data would suggest that the behavior of support is less important than the recipient's perception of that support. Perception of support is also an important predicting factor in PTSD development. According to a study by Dunmore, Clark, and Ehlers, survivors are more likely to develop PTSD when they cannot perceive positive responses from other people (1999).

Response to sexual assault disclosure. The role of positive and negative responses to survivors disclosing their assault experiences has been well documented (Ullman, 1996, Starzinski et al., 2005, Golding et al., 1989, Holstram & Burgess, 1979). In a 2003 study, Andrews, Brewin, and Rose found that in a sample of 157 adult survivors of violent crime, women received more negative reactions from friends and family than men did. This is even greater with sexual assault: Baker and associates found that women who disclosed details of sexual assault received more victim blaming and other negative reactions than women who disclosed details about other violent crime (Baker et al., 1991). Davis and Brickman found that in a sample of 105 women who had survived sexual assault, those who had received negative reactions when telling someone about the assault (as measured by the CISSI) demonstrated poor post-assault psychological adjustment. Post-assault adjustment was measured with a 90-item survey designed to identify symptoms such as somatization, depression, and anxiety (Davis & Brickman, 1991).

One type of negative response is rape myth acceptance. Here, the term "rape myth" refers to a set of erroneous or unsupported assumptions about sexual assault. Common rape myths include the idea that the survivor is to blame in some way for the assault, that the assailant isn't accountable for his or her actions, or that the survivor is lying about some element of the assault (Illinois Rape Myth Acceptance Scale--Revised, McMahon & Farmer, 2011). Rape myth

acceptance here refers to a response to a disclosure that suggests that the survivor is lying, to blame for the assault, or some other rape myth. Ullman and Filipas found that when alcohol was involved in the assault, women received more negative, victim-blaming responses (2001). Dworkin and Allen found that in a sample of 206 sexual assault survivors, those who encountered more rape myth acceptance were significantly more likely to stop disclosing their sexual assault experience.

Correlates of sexual assault disclosure and professional help seeking. Golding and colleagues collected data from 3,132 survey respondents who had experienced sexual assault. The majority (59.3%) had told a friend or a relative about the assault, followed by mental health professionals (16.1%), police (10.5), and medical professionals (9.3%, Golding et al., 1989). Participants most frequently described rape crisis centers as helpful (94.2%), followed by legal professionals (82.7%), even though only 1.9% confided in rape crisis centers, and a mere 1.6% went to a legal professional. Next on the list of helpfulness were mental health professionals (82.7%), friends and family (66.6%), medical professionals (55.6%), and police (38.2%). Clearly, the sources that are reported to be most helpful are also the most underutilized. This discrepancy is an alarming one, and prompts a closer look at what encourages survivors to disclose an assault to a professional source.

Ullman and Filipas examined correlates of sexual assault disclosure in a sample of 323 survivors. Women were more likely to report assaults perpetrated by strangers than acquaintance, date, or partner rapes (2001). Women were also more likely to disclose to formal support sources if they were physically injured or felt their lives were in danger during the attack. One possible explanation for this could be the prevalence of rape myths (i.e., a woman cannot be assaulted by a romantic partner; sexual assaults are always violent). Women may feel safer disclosing

stereotypical sexual assaults when they may be less likely to be blamed or doubted.

Kimerling and Calhoun did not find a relationship between social support and the utilization of medical services in 115 survivors of sexual assault (1994). They did, however, find a positive correlation between low social support and professional help seeking 12 months after an assault. One possible explanation for this finding is that survivors who had social support had better mental and physical health following the assault (Kimerling & Calhoun, 1994), and perhaps did not feel the need for medical services as strongly as survivors who did not have support to buffer from trauma symptoms. For survivors who do seek mental health services, Keller, Zoellner, and Feeny established positive social support as the only indicator of an early therapeutic alliance in a study of 188 adults with PTSD (2010). These findings all support the idea that social support is an important factor in post-assault recovery.

Negative responses. Negative responses to an assault include victim blaming, suggestions that the survivor should move on, implications that the survivor is lying, and invalidating statements (Ullman, 1999). Burgess and Holstram refer to the "second injury" of negative responses, such as evoking shame or victim blaming (1978). This second injury is correlated with the development of PTSD (Burgess & Holstram, 1978; Symonds, 1980). Research has also established negative social reactions as a predictor of avoidance coping, self-blame, and disengagement or withdrawal (Ullman et al., 2007).

Davis and Brickman found that unsupportive behavior was an accurate predictor of post-assault adjustment (1991). Using the SCL-90 (Derogatis, as cited in Davis & Brickman, 1991) to measure psychological well-being, they found that in a sample of 105 female survivors of sexual assault, unsupportive behaviors such as withdrawal and blame were significantly and negatively correlated with the well-being of the survivor. Negative social reactions are also indicated in the

development of PTSD. Ullman and colleagues found that survivors who received negative feedback after disclosing a sexual assault were significantly more likely to develop PTSD (Ullman et al., 2007). Negative reactions were also highly correlated with self-blame.

Herbert and Dunkel-Schetter differentiated between intentional negativity (such as explicit victim blaming) and well-intentioned, yet ineffectual, support attempts (1992). For example, a support provider may attempt to help the survivor by assisting with decision making, but this may cause the survivor to feel a lack of control which could be detrimental to post-assault recovery. Herbert and Dunkel-Schetter also highlighted the negative impact of inconsistent responses (i.e. mixed positive and negative responses, inconsistent support availability).

Ahrens, Cabral, and Abeline found that controlling behaviors (taking agency from survivors by making decisions for them) were rated as hurtful when coming from friends, family, and romantic partners (2009). Being treated differently after disclosing an assault (i.e., receiving emotional withdrawal) was found to be maladaptive to post-assault recovery, and was significantly more hurtful when coming from a romantic partner than from friends and family (Ahrens et al., 2009).

Supportive behaviors. Cutrona (1986) conducted a study on the relationship between social supportive behaviors and stress in 41 undergraduate students. Participants recorded daily descriptions of stressors and social interactions and completed the Depression Adjective Checklist (Lubin, 1965, as cited in Cutrona, 1986) every day to measure day to day emotional state. On days in which at least one stressful event occurred, Cutrona analyzed specific social support behaviors to determine what was most helpful in moderating stress. Listening to confidences and offering positive feedback both had a significant negative correlation with

depressive symptoms following a stressful event, and the total number of received helping behaviors was a predictor of fewer depressive symptoms (Cutrona, 1986).

These data show some of the specific helping behaviors that can help alleviate stress and buffer against depressive symptoms. An extensive study by Ahrens, Cabral, and Abeline examined the interaction between supportive behaviors and the position of the supporter. For example, an expression of emotional support may mean more coming from a significant other than from a legal professional. In a sample of 103 adult female survivors of sexual assault, researchers found that the identity of the support provider was a significant predictor of support efficacy. Emotional support (words of affirmation and encouragement) from mental health professionals and friends were more significantly healing than from romantic partners, family, or medical/legal professionals (Ahrens, Cabral, & Abeline, 2009). Similar patterns emerged with tangible aid (driving the survivor to an appointment with a professional, providing childcare, etc.). Tangible aid from a mental health counselor was rated as more healing than from family members or friends. A third type of response is egocentric reactions, which fall under the umbrella of negative responses as defined by Ullman (2000). Egocentric reactions refer to a support giver responding to a sexual assault disclosure in a self-centered way, such as becoming so angry or upset that the survivor needs to calm him or her down. Interestingly, egocentric reactions were perceived as moderately healing from all sources of support (Ahrens et al., 2009).

While this seems to be a discrepancy from the idea that positive responses are correlated with better post-assault adjustment and recovery, there are a few possible explanations for this finding. Studies by Kanaisty and Norris (1992), Davis and Brickman (1991), and Dunmore, Clark, and Ehlers (1999), suggest that the survivor's perception of support is more important than the supportive behavior. This is further supported by Herbert and Dunkel-Schetter's 1992

study, which indicated that well-intentioned efforts to provide support could sometimes be more hurtful than helpful. An egocentric reaction, while taking the focus away from the survivor, displays strong emotion. It is possible that survivor's perceive this strong emotional reaction as evidence that they are deeply cared about, and that their social support network is upset to hear about a negative experience. This demonstration of emotional involvement could be initially comforting in the aftermath of an assault.

Ahrens and colleagues also found that controlling behaviors were rated as moderately healing when coming from a mental health professional, while controlling behaviors from romantic partners, friends, family, and medical/legal professionals were rated as more hurtful (Ahrens et al., 2009). A possible explanation for this effect could be that many clients go into counseling with the expectation that their counselor is an expert and an excellent source of information (Watsford & Rickwood, 2014). This may mean that controlling behaviors are perceived as the therapist doing his or her job, and line up with the survivor's expectations for therapy. Again, this supports the idea that the perception of support is key in a survivor's emotional recovery.

Spousal support is another factor in post-assault symptoms. A 2014 study by Evans and colleagues indicated that spousal support was more important for men than for women in buffering against trauma symptoms. A possible explanation is that women tend to seek support from a wider sample of friends and family, rather than relying on a primary support giver (Verhofstadt, Busse, & Ickes, 2007; Walen & Lachman, 2000). This smaller social support network may indicate that men rely more heavily on support from one source.

In 2006, Borja and colleagues conducted a study of 115 female college students who had experienced sexual assault. None of the participants had been assaulted by either a spouse or a

stranger. Participants completed a battery of assessments to determine social support, post-assault symptoms, and PTSD diagnostic criteria. The results showed a positive predictive correlation between informal negative support (negative reactions from friends, family, and romantic partners) and PTSD development. Further analysis showed that informal negative support increased the likelihood of PTSD development by approximately 9% (Borja, Callahan, & Long, 2006). Additionally, the combination of formal and informal positive support predicted 49% of post-assault growth and adjustment.

Discussion.

The findings of this review indicate that social support, both positive and negative, form a complex relationship in predicting survivor well-being and post-assault recovery. Perhaps the clearest indication of maladaptive symptoms, including depression, anxiety, somatization, and PTSD, is the receipt of negative responses. Negative responses, especially informal ones, were associated with increased self-blame, slower recovery rates, and increased symptomology.

With this in mind, it is a reasonable assumption that the opposite is true of positive social support. Looking at the body of literature as a whole, it appears that survivors with stronger supportive networks have a higher chance of post-assault recovery. While the purpose of this review is not to examine the role of professional support alone, the efficacy of mental health counseling cannot be ignored altogether. While both informal and formal support are important in growth and recovery after a sexual assault, a combination of both professional and informal social support appears to be especially effective in promoting survivor well-being.

These findings are not the only predictive factors in post-assault adjustment. Perhaps the clearest result of this review is that the survivor's perception of responses is an important moderating factor in how social support is received. A response that is typically viewed as

negative, such as controlling or egocentric behavior, may be adaptive for a survivor if it is interpreted as caring or helpful. This effect is further mediated by the role of the support giver in the survivor's life; a reaction from a romantic partner may be perceived very differently than the same reaction from a friend or professional.

Future research and limitations.

As noted in the introduction, many researchers have varying definitions of what comprises social support. Many of the studies used in this review utilized different measures and methodologies in examining both positive and negative social support. For this reason, it is challenging to compare data collected from different sources.

The majority of data focuses on female survivors of sexual assault, making it difficult to examine gender differences. While the majority of sexual assault survivors are female, there are still an estimated 30,000 male survivors (Rape, Assault, and Incest National Network, 2016). Future research is required to better understand the needs and challenges faced by this demographic.

Other demographic data include race, religion, sexual orientation, gender identity, socio-economic status, and more. For example, one study examining 413 female African American sexual assault survivors found that African American women are especially at risk for depression, substance abuse, PTSD, and suicidality following a sexual assault (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010). Interaction effects included income and previous childhood sexual abuse. Other research has established a connection between identifying as lesbian or bisexual and increased likelihood of negative health outcomes following a sexual assault, including a diminished sense of control and agency (Lehavor, Walters, & Simoni, 2010). Future researchers should bear in mind that demographic variables may have a significant effect

on the individual experiences of sexual assault survivors. In addition, the interaction between multiple demographic variables in sexual assault survivors when predicting post-assault recovery has been scarcely researched. In order to further the collective body of knowledge on post-assault recovery, more research is needed to fully examine these interactions.

Resources

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Things to avoid

Sometimes, even a well-meaning statement or question can make the survivor of an assault feel like it was their fault. This is called **victim blaming**, and can have negative effects on a survivor.

Some questions or statements to avoid include:

What were you wearing?

Were you flirting with them in some way?

You must have done something to cause it.

What were you even doing there in the first place?

Were you drinking?

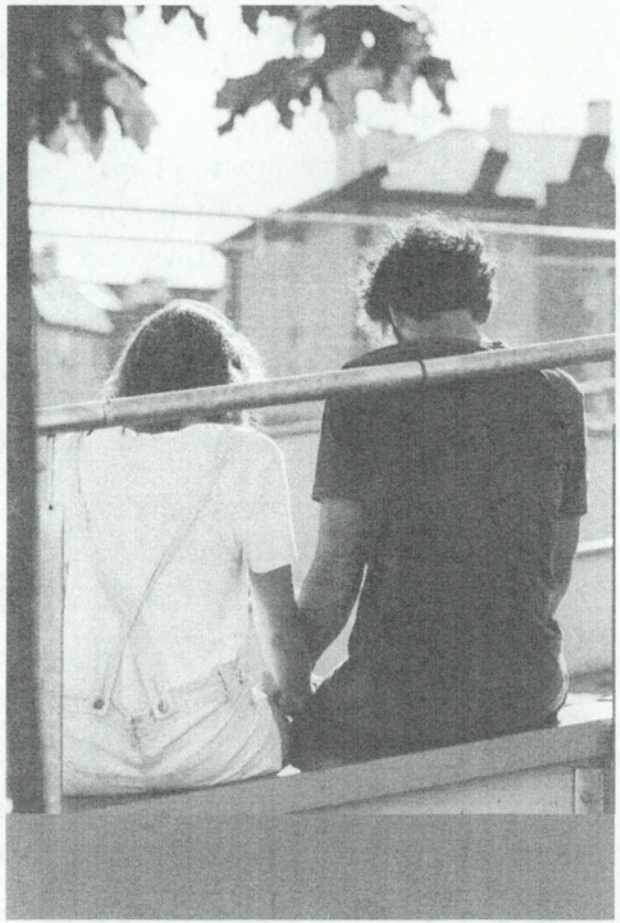
If you had/hadn't done _____, this wouldn't have happened.

This happened a while ago. Why are you still upset? Just move on.

Sexual assault occurs when someone makes a decision to assault someone—it's not about the victim or their surroundings. Instead of suggesting things your loved one could have done differently, listen and offer support.

How to Support a Survivor of Sexual Assault

What to do, what not to do, & how to avoid burn out



Here are some ways you can support your loved one while they recover:

Listen. If they want to talk about what happened, listen to everything they have to say. Don't force them to talk if they aren't ready—sometimes, repeating the story can be exhausting.

Be empathetic. Saying things like, "I'm so sorry you're going through this," or "This has to be really hard. What can I do to help?" will help your loved one know that you support them. Be careful not to say that you know exactly what they're going through—everyone's experience is different and you may not fully understand what they're experiencing.

Offer support. Ask your loved one what they need, and try to be there for them. Everyone copes differently, so make sure you're providing what they need, instead of what you think you'd want in the same situation.

Be reassuring. There is no right or wrong way to react to being assaulted. Some survivors feel different emotions than they expect, and that's ok. Tell your loved one that what they are feeling is normal and ok.

Resources for Survivors

Peer support is very important for survivors of sexual assault, but there are many other professional resources.

National Sexual Violence Resource Center: nsvrc.org

National Sexual Assault Hotline: 800-656-HOPE

Ball State Office of Victim Services: 765-285-9063

Ball State Counseling Center: 765-285-1736

University Police Department: 765-285-1111

Ball Memorial Hospital Emergency Department: 765- 747-3241

Health Center

Student Legal Services

Remember, not everyone is comfortable going to the hospital to do a rape kit, or filling out a police report. Don't pressure someone into doing something they aren't ready for.

Resources for You

Offering support to someone who has experienced trauma can be difficult and overwhelming. It's normal to feel tired, discouraged, or stressed, and there's nothing selfish about taking care of your own needs. Communicate with others who know what happened so you can all work together to provide support.

Make sure you have someone you can talk to, whether that be your friends, family, a mentor, or a professional. The more support you have, the less likely you are to experience **burn out**, or fatigue related to taking care of someone.

Ball State Counseling Center: 765-285-1736